



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Universal DME

Respondent Name

Allmerica Financial Benefit Insurance Company

MFDR Tracking Number

M4-17-0368-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

October 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB it stated that claim/service lacks information which is needed for adjudication, additional information is supplied using remittance advice remarks codes whenever appropriate, the supply charge was disallowed as it was not adequately identified. We have sent all proper documentation for their review, including the Certificate of Medical Necessity as well as the company's authorization#48529029-UMO-24. On 05/11/2016 we sent our appeal for payment, and on 06/07/2016 the appeal was denied."

Amount in Dispute: \$1,100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Given no violation of the Workers' Compensation Act or division rules, CorVel respectfully requests the division issue a decision indicating the requestor is entitled to \$0.00 reimbursement for date of service 01/26/16; HCPCS Code E0676 (-NU) based on insufficient documentation to demonstrate or justify that payment sought would be a fair and reasonable rate of reimbursement for the services in dispute and pursuant to the division rules referenced herein."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26, 2016	E0676, NU	\$1,110.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.1(f) which details medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 304 – Submit supply house invoice for additional payment
 - ORC – See additional information
 - P5 – Based on payor reasonable/customary fees
 - NU – New equipment
 - 193 – Original payment decision maintained
 - B13 – Payment for service may have been previously paid
 - W3 – Appeal/reconsideration

Issues

1. What is the applicable fee rule?
2. Did the requestor provide documentation to support requested payment amount?

Findings

1. The requester seeks additional reimbursement of \$1,100.00 for code E0676.

The carrier reduced the payment with the following reason codes P5 – Based on payor reasonable/customary fees.”

The service in dispute is durable medical equipment which are subject to 28 Texas Administrative Code 134.203(d)(3) which states,

The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or

(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

Review of the applicable DMEPOS fee schedule finds no fee schedule amount for E0676 -NU.

Review of the Texas Medicaid fee schedule finds no fee schedule amount for E0676 - NU.

The service in dispute will be reviewed pursuant to 28 Texas Administrative Code §134.203(f) which states,

For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

2. The division concluded above that §134.1(f) applies and states,
Fair and reasonable reimbursement shall:
 - (1) be consistent with the criteria of Labor Code §413.011;
 - (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
 - (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

For that reason, 28 Texas Administrative Code §133.307(c)(2)(O) also applies and, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.”

Review of the submitted documentation finds:

- The requestor does not discuss or demonstrate how reimbursement of \$1,100.00 for code E0676 is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1(f).

For the reasons stated, the division concludes that the requestor failed to support its request for reimbursement. For that reason, no reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	October 31, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.